

Application Fee_____

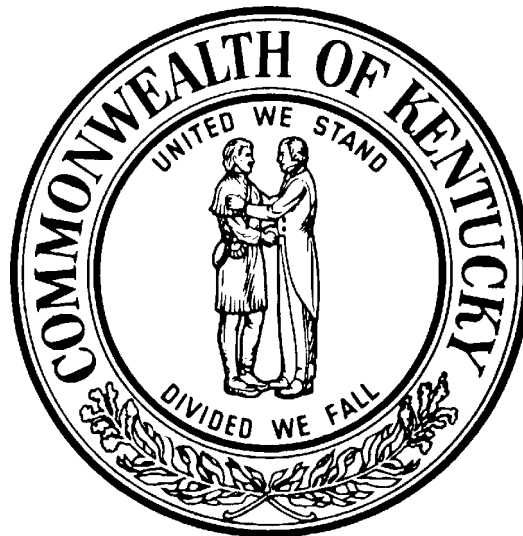
Date Paid_____

Registration No. T _____

Registration Date_____

For office use only

DENTAL TECHNICIAN REGISTRATION APPLICATION



KENTUCKY BOARD OF DENTISTRY
312 WHITTINGTON PKWY, SUITE 101
LOUISVILLE, KENTUCKY 40222
(502) 429-7280
FAX (502) 429-7282

ALL DENTAL LABORATORY TECHNICIANS WITH TWO OR MORE YEARS EXPERIENCE AND/OR EDUCATION MUST REGISTER WITH THE BOARD. ALL QUESTIONS OR STATEMENTS MUST BE ANSWERED. INCOMPLETE APPLICATIONS WILL BE RETURNED. PLEASE PRINT OR TYPE ALL ANSWERS.

1. Last name _____ First Name _____ MI _____

Home Address _____
Street City State Zip

Home Telephone _____ S.S.N. _____
Area code Number

2. Do you own all or part of a laboratory in Kentucky? Yes _____ No _____ What % _____

Name of Laboratory Address City Zip

3. I am a: (check all that apply)

- a. _____ Dental Technician with two or more years experience and/or education
b. _____ Certified Dental Technician. Certified in: _____
Certification no. _____
(Attach copy of current CDT card or certificate to application)
c. _____ Other _____

4. I work for: (check all that apply to current work situation, both full and part time).

- a. _____ A commercial dental laboratory, accepting work from any licensed dentist or other commercial dental laboratory.
b. _____ A private dental office laboratory, operated for one or a limited number of licensed dentists practicing in the same location.
c. _____ A state or federally owned institution. (Includes military base, veterans hospitals, prisons, state school, state hospitals, or college or universities laboratories).
d. _____ Other _____

5. Name of Employer/s, both full and part time. Attach separate sheet if necessary.

Lab Owners Name _____ Lab Owners Name _____

Laboratory Name _____ Laboratory Name _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone _____ Phone _____

6. Are you in charge of the laboratory operation? Yes _____ No _____

7. Are you a supervisor or department head? Yes _____ No _____

8. Check all phases of dental laboratory work in which you have had two or more years of experience:

_____ Full Dentures _____ Partial Castings _____ Ceramics _____ Relines & Repairs

_____ Orthodontics _____ Gold Crown & Bridge _____ Other

9. Did you graduate from a two year dental technology school? Yes _____ No _____

10. Give Name of School _____
State _____ Date Graduated _____ Degree Attained _____

11. Do you currently have an obligation in a financial aid program administered by the Kentucky Higher Education Assistance Authority (KHEAA)? Yes No

12. If YES to #11, are you in default of the repayment obligation? (per HB296) Yes No

13. If you work for a “private” dental laboratory, (located in a dental office and doing work for dentists/s in that office only please have the supervising dentist/s sign below:

I, _____ DDS or DMD and

I, _____ DDS or DMD,
(If applicable)

certify that _____ works only under my complete supervision and control, except as noted in item 5. (If more than two supervising dentists, attach separate sheet).

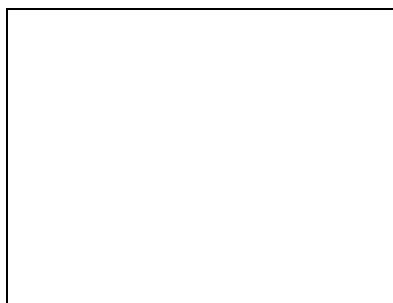
Signed _____

Date _____ License No. _____

Signed _____

Date _____ License No. _____

14. I submit herewith a 2" X 2" bust photograph of technician taken within the past six months. Please place photograph in the box provided. No hats please.



AFFIDAVIT

STATE OF _____

COUNTY OF _____

On this _____ day of _____ 20____ stating that he/she has answered the questions contained in this application truthfully and completely to the best of his/her knowledge, and that he/she has not ever been convicted of a felony, nor has he/she ever been convicted of the illegal practice of dentistry in this or any other state, and that this statement and the previously given information is for the purpose of obtaining a Kentucky Dental Laboratory Technician Registration Certificate to enable him/her to practice that trade in this State. He/she further states that he/she is aware of the penalties for giving false information.

Signature of applicant _____

Sworn to and subscribed before me, this _____ day of _____ 20____

Signature of Notary _____

My commission expires _____

(SEAL)

NOTE: Make all checks or money orders in the amount of \$10 payable to the Kentucky Board of Dentistry and submit application and fee to:

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(502) 429-7280**